

**STATE OF NEW YORK
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE
WITH SPECIAL NEEDS**

In the Matter of the Appeal of

██████████

Pursuant to § 494 of the Social Services Law

**FINAL
DETERMINATION
AFTER HEARING**

ADJUDICATION CASE

Vulnerable Persons' Central Register
Justice Center for the Protection of People with
Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
Appearance Waived

Justice Center for the Protection of People with
Special Needs
161 Delaware Avenue
Delmar, New York 12054-1310
By: Thomas Parisi, Esq.

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██

By: Aaron E. Kaplan, Esq
Associate Counsel
Civil Service Employees Association, Inc.
143 Washington Avenue
Albany, New York 12210

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The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

ORDERED: The request of ██████████ that the substantiated report dated ██████████ ██████████, ██████████, dated ██████████ be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The Offense is properly categorized as a Category 2.

NOW THEREFORE IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

DATED: Schenectady, New York
March 17, 2015



David Molik
Administrative Hearings Unit

JURISDICTION

The New York State Vulnerable Persons' Central Register (the "VPCR") maintains a report substantiating [REDACTED] (the "Subject") for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a Subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a "substantiated" report dated [REDACTED], [REDACTED] [REDACTED], dated [REDACTED] of neglect by the Subject against a Service Recipient.

2. The initial report alleges, in pertinent part, that on or about [REDACTED], the Subject committed an act of neglect at [REDACTED], (the "facility") by leaving a Service Recipient behind after a Fresh Air Break in the facility courtyard, thereby allowing him to attempt to escape and to become injured as a result. (Justice Center Exhibit 1)

3. On [REDACTED], the Justice Center substantiated the report against the Subject for neglect. The Justice Center concluded that:

Offense

It was alleged that on [REDACTED], at [REDACTED], [REDACTED], located at [REDACTED], while acting as a custodian (MHTA), you neglected a service recipient by failing to provide proper supervision, when you left him in the courtyard alone, leading to his attempted elopement and subsequent laceration of his right hand.

This offense has been SUBSTANTIATED as Category 2 neglect pursuant to Social Services Law § 493.

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4. An Administrative Review was conducted and, as a result, the substantiated report was retained.

5. The facility, located at ██████████, is a psychiatric facility, and is operated by the New York State Office of Mental Health (OMH), which is a *facility or provider agency* that is subject to the jurisdiction of the Justice Center.

6. At the time of the alleged neglect, the Subject, ██████████ had been employed at the facility for approximately three years as a Mental Health Therapy Aid (“MHTA”). Her regular shift was from ██████████ (Testimony of ██████████; Subject)

7. At the time of the alleged neglect, the Service Recipient was 41 years of age and had been transferred to the facility ██████████ on ██████████. The Service Recipient had been in and out of psychiatric facilities and jails from the time that he was 14 years old. Prior to this incident, the Service Recipient had been back and forth between units in the facility and the ██████████ continuously since ██████████. The Service Recipient is a person with diagnoses of bipolar disorder with psychotic features and schizophrenia paranoid type, chronic and continuous. He has a well-documented and known history of actually escaping, as well as numerous unsuccessful escape attempts. At the time of the incident, and partially as a result of his escape history, the Service Recipient was on 15 minute checks, instead of the standard 30 minute checks. Furthermore, there had been a discussion on or about the date of the incident, at the morning staff meeting about designating the Service Recipient to be on an “unofficial 1:1” because of his high risk of escape attempts. (Justice Center Exhibit 4 and Testimony of ██████████; Subject)

8. On ██████████, ██████████ was on duty at her regular assignment, the ██████████ unit. From 3:00 p.m. to 4:00 p.m., staff members ██████████ and ██████████ were assigned to

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“Fresh Air,” ██████████ was assigned to “Accountability,” and ██████████ was assigned to “Float.”
(Justice Center Exhibit 16)

9. The 3:00 p.m. Fresh Air Break was unusual on the day in question. It started late because ██████████ and ██████████ were unable to be ready at the specified time. At 3:00 p.m., ██████████ was participating in a discussion with another resident and a facility doctor. At this time, ██████████ had been called to a separate nearby unit to assist with a difficult resident on that unit. (Justice Center Exhibit 4)

10. At approximately 3:10 p.m., while returning to ██████████, ██████████ encountered a group of residents who were standing just outside of the unit. The residents were lined up, waiting by the locked door to the stairs for the Fresh Air Break to begin. Instead of going back into ██████████, ██████████ simply unlocked the door to the stairs and escorted whoever was there down to the courtyard. ██████████ did this without waiting for the other escort or checking with ██████████, who was responsible for Accountability. (Testimony of ██████████; Subject)

11. In the meantime, in the absence of ██████████, ██████████ offered to be the other escort and her supervisor agreed to cover ██████████ Float assignment. Just then, ██████████ appeared and readily agreed to the offer that ██████████ take over the Fresh Air assignment for her. (Testimony of ██████████; Subject)

12. At that point, ██████████ was far ahead of ██████████ and she immediately escorted the three or four residents, who were still waiting near her, down to the courtyard. When ██████████ and the residents, who went with her, arrived in the courtyard, ██████████ was there with the other ██████████ residents, who he had escorted to the courtyard. There were also approximately ten residents from ██████████ in the courtyard, with one escort, as well. (Testimony of ██████████; Subject)

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13. The Fresh Air Break escorts normally perform a head count of the residents entering and leaving the courtyard with them, but no head count was done that day. (Testimony of ██████████; Subject)

14. Upon entering the courtyard, ██████████ sat on a bench and supervised the residents that she had escorted down. She was also able to observe some of the other ██████████ residents who had been escorted by ██████████ and she did notice that the Service Recipient, who had been escorted by ██████████, was present in the courtyard. (Testimony of ██████████; Subject)

15. After five to ten minutes, the escorts in the courtyard called an end to the break and began moving the residents back to their respective units, upstairs at the same time. This resulted in a large group of people ascending the stairs together, with no delineation between the residents of the two different units. (Justice Center Exhibit 4)

16. The ██████████ residents were led by ██████████ and ██████████ was the last staff member to leave the courtyard. She visually surveyed the courtyard, went inside, locked the door behind her and went upstairs. (Testimony of ██████████; Subject)

17. When ██████████ arrived on the unit, she was immediately confronted by ██████████, who had the Accountability assignment. ██████████ asked ██████████ where the Service Recipient was as he had not returned to the unit and ██████████ responded that he had come upstairs. When ██████████ contradicted ██████████, ██████████ quickly started toward the bathroom to check there for the Service Recipient. As she passed the window, she looked out and saw the Service Recipient sitting on a bench in the courtyard holding his injured hand. (Testimony of ██████████; Subject)

18. Subsequently, it was discovered that the Service Recipient had deliberately

██████████ remained in the courtyard and hidden behind some bushes. After ██████████ had gone upstairs, he then climbed to a rooftop where he then fell and injured himself. (Justice Center Exhibit 4)

ISSUES

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegations constitute neglect.
- Pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute.

APPLICABLE LAW

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A “substantiated report” means a report “... wherein a determination has been made as a result of an investigation that there is a preponderance of evidence that the alleged act or acts of abuse or neglect occurred...” (Title 14 NYCRR 700.3(f))

Pursuant to SSL §§ 494(1)(a)(b) and (2), and Title 14 NYCRR § 700.6(b), this hearing decision will determine: whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report, and if there is a finding of a preponderance of the evidence; whether the substantiated allegations constitute neglect; and pursuant to Social Services Law § 493(4), the category of neglect that such act or acts constitute.

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488:

1. "Reportable incident" shall mean the following conduct that a mandated reporter is required to report to the vulnerable persons' central register:
- (a) "Physical abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Such conduct may include but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.
 - (b) "Sexual abuse," which shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law. For purposes of this paragraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of a service provider shall not be considered a custodian if he or she has sexual contact with another service recipient who is a consenting adult who has consented to such contact.
 - (c) "Psychological abuse," which shall mean conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution. Such conduct may include but shall not be limited to intimidation, threats, the display of a weapon or other object that could reasonably be perceived by a service recipient as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury, taunts, derogatory comments or ridicule.
 - (d) "Deliberate inappropriate use of restraints," which shall mean the use of a restraint when the technique that is used, the amount of force that is used or the situation in which the restraint is used is deliberately inconsistent with a service recipient's individual treatment plan or behavioral intervention plan, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other person. For purposes

of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

- (e) "Use of aversive conditioning," which shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services in the absence of a person-specific authorization by the operating, licensing or certifying state agency pursuant to governing state agency regulations. Aversive conditioning may include but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, the withholding of meals and the provision of substitute foods in an unpalatable form and movement limitations used as punishment, including but not limited to helmets and mechanical restraint devices.
- (f) "Obstruction of reports of reportable incidents," which shall mean conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment or supervision of a service recipient, actively persuading a mandated reporter from making a report of a reportable incident to the statewide vulnerable persons' central register with the intent to suppress the reporting of the investigation of such incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with governing state agency regulations, policies or procedures; or, for a mandated reporter who is a custodian as defined in subdivision two of this section, failing to report a reportable incident upon discovery.
- (g) "Unlawful use or administration of a controlled substance," which shall mean any administration by a custodian to a service recipient of: a controlled substance as defined by article thirty-three of the public health law, without a prescription; or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article thirty-three of the public health law, at the workplace or while on duty.
- (h) "Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (a) through

(g) of this subdivision if committed by a custodian; (ii) failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the facility or provider agency, provided that the facility or provider agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; or (iii) failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article sixty-five of the education law and/or the individual's individualized education program.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493:

4. Substantiated reports of abuse or neglect shall be categorized into one or more of the following four categories, as applicable:
 - (a) Category one conduct is serious physical abuse, sexual abuse or other serious conduct by custodians, which includes and shall be limited to:
 - (i) intentionally or recklessly causing physical injury as defined in subdivision nine of section 10.00 of the penal law, or death, serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, or consciously disregarding a substantial and unjustifiable risk that such physical injury, death, impairment or loss will occur;
 - (ii) a knowing, reckless or criminally negligent failure to perform a duty that: results in physical injury that creates a substantial risk of death; causes death or serious disfigurement, serious impairment of health or loss or impairment of the function of any bodily organ or part, a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical

assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor; or is likely to result in either;

(iii) threats, taunts or ridicule that is likely to result in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(iv) engaging in or encouraging others to engage in cruel or degrading treatment, which may include a pattern of cruel and degrading physical contact, of a service recipient, that results in a substantial and protracted diminution of a service recipient's psychological or intellectual functioning, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor;

(v) engaging in or encouraging others to engage in any conduct in violation of article one hundred thirty of the penal law with a service recipient;

(vi) any conduct that is inconsistent with a service recipient's individual treatment plan or applicable federal or state laws, regulations or policies, that encourages, facilitates or permits another to engage in any conduct in violation of article one hundred thirty of the penal law, with a service recipient;

(vii) any conduct encouraging or permitting another to promote a sexual performance, as defined in subdivision one of section 263.00 of the penal law, by a service recipient, or permitting or using a service recipient in any prostitution-related offense;

(viii) using or distributing a schedule I controlled substance, as defined by article thirty-three of the public health law, at the work place or while on duty;

(ix) unlawfully administering a controlled substance, as defined by article thirty-three of the public health law to a service recipient;

(x) intentionally falsifying records related to the safety, treatment or supervision of a service recipient, including but not limited to medical records, fire safety inspections and drills and supervision checks when the false statement contained therein is made with the intent to mislead a person investigating a reportable incident and it is reasonably

foreseeable that such false statement may endanger the health, safety or welfare of a service recipient;

(xi) knowingly and willfully failing to report, as required by paragraph (a) of subdivision one of section four hundred ninety-one of this article, any of the conduct in subparagraphs (i) through (ix) of this paragraph upon discovery;

(xii) for supervisors, failing to act upon a report of conduct in subparagraphs (i) through (x) of this paragraph as directed by regulation, procedure or policy;

(xiii) intentionally making a materially false statement during an investigation into a report of conduct described in subparagraphs (i) through (x) of this paragraph with the intent to obstruct such investigation; and

(xiv) intimidating a mandated reporter with the intention of preventing him or her from reporting conduct described in subparagraphs (i) through (x) of this paragraph or retaliating against any custodian making such a report in good faith.

- (b) Category two is substantiated conduct by custodians that is not otherwise described in category one, but conduct in which the custodian seriously endangers the health, safety or welfare of a service recipient by committing an act of abuse or neglect. Category two conduct under this paragraph shall be elevated to category one conduct when such conduct occurs within three years of a previous finding that such custodian engaged in category two conduct. Reports that result in a category two finding not elevated to a category one finding shall be sealed after five years.
- (c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.
- (d) Category four shall be conditions at a facility or provider agency that expose service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training or supervision. Category four also shall include instances in which it has been substantiated that a service recipient has been abused or neglected, but the perpetrator of such abuse or neglect cannot be identified.

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be

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determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of evidence, the substantiated report must be amended and sealed.

DISCUSSION

The Justice Center has established by a preponderance of evidence that ██████████ committed the neglect as alleged in the substantiated report. Specifically, the evidence establishes that ██████████ volunteered for the Fresh Air assignment, and that knowing that the Service Recipient was an escape risk; she failed to take the necessary steps to ensure his safe return from the Fresh Air Break. The act committed by the Subject constitutes neglect. The category of the affirmed substantiated neglect that such act constitutes is Category 2.

In support of its substantiated findings, the Justice Center presented a number of documents obtained during the investigation. (Justice Center Exhibits 1-23) The investigation underlying the substantiated report was conducted by ██████████ ██████████, who was the only witness who testified at the hearing on behalf of the Justice Center. ██████████ testified on her own behalf and presented three documents into the record. (Subject Exhibits 1-3)

The facts giving rise to the substantiated finding are essentially undisputed and the parties appear to be in agreement as to all material facts. ██████████ was a Fresh Air Break escort, she was the last staff member to leave the courtyard at the end of the break, the Service Recipient was left behind in the unsupervised courtyard and he sustained an injury immediately thereafter. (Testimony of ██████████; Subject)

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The issue in the present case is whether ██████████ conduct constituted an “action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury...” as defined by SSL § 488(1)(h), under the circumstances as set out in the facts herein.

One of the relevant factors in this case is that the Service Recipient was known by ██████████ ██████████ to be an escape risk. In her hearing testimony, ██████████ admitted that she was aware that the Service Recipient had made numerous escape attempts in the past, some more successful than others. ██████████ also testified that there had been a discussion on the date of the incident, or the day before, at the morning staff meeting about designating the Service Recipient to be on an “unofficial 1:1” because of his high risk of escape attempts. Also, she knew that the Service Recipient was on a special fifteen minute check list, instead of the regular thirty minute checks. (Testimony of ██████████; Subject)

In short, ██████████ was well aware that the Service Recipient had repeatedly sought to escape the facility in the past and that the concern was still very much alive at the time of the incident.

The facility’s written policy delineating the escort duties of custodians assigned to courtyard/Fresh Air Breaks is minimal, at best. The Justice Center provided a one page excerpt of the facility policy; the ██████████ *Policy & Procedure* entitled *Escort Policy revised last on July, 2009*. (Justice Center Exhibit 21)

Under heading three, entitled *Courtyard Breaks (Fresh Air Breaks)* the policy states;

- a) Observation of the group during the break is the assigned duty, meaning that the staff must be looking at the patients, and should not be using personal music devices (MP3s, iPod, Walkman, etc.), using personal cell phones for personal calls, etc.

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b) All courtyard breaks should have two staff assigned, each positioned at a different part of the courtyard. ... (Justice Center Exhibit 21)

There was no evidence adduced at the hearing that ██████████ had failed to comply with this scant directive on the date of the incident. She spent her time in the courtyard properly attending to the residents, away from the other escort, as required under the policy.

The Justice Center introduced ██████████ 11 page *Employee Course Transcript* which shows that on ██████████, ██████████ received a one-hour training on *Patient Escort Policy*. This evidence, regarding ██████████ relevant training as to her duties as a custodian, did not provide any specifics as to the substance of the training and made clear that facility training regarding courtyard break safety practices had not been emphasized or refreshed. (Justice Center Exhibit 23)

After considering all of the evidence, ██████████ cannot be chargeable for violating facility training or policy with regard to the incident. The question then becomes whether there had been any neglect by ██████████ otherwise. It was clear from the evidence that ██████████ did not take all reasonable steps available to her to make sure that the Service Recipient had gone inside from the courtyard before she went in herself and locked the door thereafter. This failure on ██████████ part was a breach of her duty that constituted an act of neglect under SSL § 488(1)(h).

██████████ hearing testimony was that, as an escort, she “usually” performs a head count at the start of a Fresh Air Break, but that she did not attempt to do so on this occasion. This deviation from her normal practice was, partly because ██████████ had gone down to the courtyard with an unspecified number of residents before her and, partly because there were residents from the other unit comingling with the ██████████ residents in the courtyard, making a head count difficult. (Testimony of ██████████; Subject)

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At the end of the break, again, ██████████ did not count the ██████████ residents leaving the courtyard. In her interrogation, ██████████ likened the flow of people in the stairwell to “cattle” moving as a herd, indicating that she could not differentiate between the residents of the two units. (Justice Center Exhibit 22)

██████████ testified that, as the last staff member in the courtyard, she did not perform a head count of the residents going upstairs at the end of the break, because no head count had been performed of the residents going downstairs at the beginning of the break and, therefore, there was no basis for comparison. (Testimony of ██████████; Subject)

Although, an end of break head count might have been a more “challenging” assignment than usual because of these facts, the difficulties in actually determining how many residents from ██████████ were in the courtyard that afternoon, would not have been insurmountable. Had ██████████ taken the steps to determine the number of ██████████ residents who were present in the courtyard and the number leaving the courtyard, the Service Recipient’s absence would have been detected before ██████████ went inside. Fresh Air Break head counts are a critical duty of the courtyard escorts and that is why ██████████ “usually” does them. The need for that essential safeguard was not obviated due to the unfortunate deviation from routine that day.

██████████ counsel argued that the Accountability person has the Observation Flow Sheets and Patient Accountability Records, and therefore, she is the one responsible to keep an accurate record of those residents who enter and exit the ██████████ unit. His position was that, because the escorts have no specific recording requirements, they should not be chargeable for the responsibility to know exactly how many and which residents are going into and returning from the courtyard with them.

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As this case clearly demonstrates, not only must staff be aware of who enters and exits the unit, but, they also must know who enters and exits the courtyard to avoid exactly the sort of problem that has arisen here. Having an Accountability person keeping track of those residents who enter and exit the unit is an essential safeguard as part of the effort to monitor the residents' whereabouts, and was crucial in this case. However, that cannot absolve the Fresh Air Break escorts from monitoring who and how many residents they have with them, as was also so plainly illustrated in the case at hand.

██████████ testified that because of the physical layout of the courtyard, there was no way to see the entire courtyard from one vantage point, as there are numerous obstructions such as trees and bushes. Despite this acknowledgment, ██████████ testified that she did not physically look around the courtyard to ensure that all of the residents did, in fact, go upstairs. Instead, she testified, she performed a visual "scan" around her to satisfy herself that no residents had stayed behind. (Testimony of ██████████; Subject)

The suggestion here was that, ██████████ should not be faulted because she failed to notice the hiding Service Recipient, when the other residents were going back to the unit, as the entire courtyard area was not open and easily visible when ██████████ performed her visual scan.

It was incumbent upon ██████████ to look around carefully, and to perform a physical check of the courtyard to make sure that no one was left behind. ██████████ had seen the Service Recipient in the courtyard and knew that he was an escape risk. ██████████ knew that she had not taken the usual precaution of a head count and she had taken no other steps to keep track of the ██████████ residents in the courtyard and returning to the unit at the end of the break. Had ██████████ checked the courtyard carefully, before leaving it, the Service Recipient may well have been detected before ██████████ left the area.

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██████████ repeated in her interrogation and her testimony that she only knew who those residents were that went down with her, but not the ones who went down with ██████████. The fact that the residents did not go to the courtyard together as one group did not acquit ██████████ of responsibility for each of the residents. ██████████ testified that she was aware that each staff member is fully responsible for each and every one of the ██████████ unit residents in the courtyard.

In the final analysis, based on all of the evidence, it is concluded the Justice Center has met its burden of proving by a preponderance of the evidence that ██████████ committed the neglect as alleged in the substantiated report. The substantiated report will not be amended or sealed.

Although the report will remain substantiated, the next question to be decided is whether the substantiated allegation constitutes the category of neglect as set forth in the substantiated report. ██████████ neglect in this case resulted in an injury to the Service Recipient that was preventable. Accordingly, it is determined that the substantiated report is properly categorized as Category 2.

Category 2 conduct under this paragraph shall be elevated to Category 1 conduct when such conduct occurs within three years of a previous finding that such custodian engaged in Category 2 conduct. Reports that result in a Category 2 finding not elevated to a Category 1 finding shall be sealed after five years.

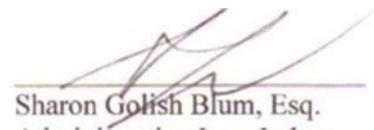
DECISION: The request of ██████████ that the substantiated report dated ██████████
██████████, ██████████, dated ██████████ be amended

and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The Offense is properly categorized as a Category 2.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

DATED: March 2, 2015
Plainview, New York



Sharon Golish Blum, Esq.
Administrative Law Judge